



**Maryland 4-H Accident / Incident Report Form**

*The Maryland Cooperative Extension is requesting information to report the nature and circumstances of accidents and incidents occurring at MCE programs. If you do not provide requested information the report may be without pertinent information. The information you provide may be shared with MCE employees, MCE volunteers, officials, medical personnel, and others as appropriate.. Information provided to MCE may also be shared among offices within the University of Maryland and the University System of Maryland and outside entities as necessary or appropriate in the conduct of legitimate University business and consistent with applicable law. Because the University is a State educational institution, such information (excludes medical and psychological information) may also be subject to disclosure under the Maryland Access to Public Records Act (the "Public Records Act."). Individuals may inspect and/or correct their personal information as provided by the Public Records Act and/or other applicable law or University Policy.*

Camp / Event Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Incident/Accident: \_\_\_\_\_ Hour: \_\_\_\_\_  a.m.  p.m.

Type of incident:  Behavioral  Accident  Epidemic Illness  Other (describe): \_\_\_\_\_

Address / Location of Event: \_\_\_\_\_

Name of injured/individual person(s) involved: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Sex: \_\_\_\_\_

Check one:  Participant  Camper  Visitor  MCE Volunteer  Employee  Parent

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Parent/Guardian (if minor): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Addresses/Telephone Number of Witnesses (Attach signed statements):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Describe the Accident/Incident in detail, including the sequence of activities and what the individual/injured was doing.  
[Attach extra pages if needed]:

---

---

---

---

Where occurred? [Specify location of accident/incident, including location of individual/injured and witness(es). Use diagram to locate persons/objects, if appropriate]:

Was individual/injured participating in an activity at time of injury?:  Yes  No

If so, what activity?: \_\_\_\_\_

\_\_\_\_\_

Actions taken at time of incident/accident: by Extension Employee(s) or MCE volunteer(s) \_\_\_\_\_

\_\_\_\_\_

**Medical Report of Accident / Incident**

**Were parents notified?** Yes \_\_\_ No \_\_\_ By: Writing \_\_\_ Phone \_\_\_  Other \_\_\_\_\_

By whom? \_\_\_\_\_ Title: \_\_\_\_\_ When? [time & date]: \_\_\_\_\_

Parent's Response: \_\_\_\_\_

Description of Injuries: \_\_\_\_\_

**If first aid/treatment was given at the camp/event site, describe:**

Where: \_\_\_\_\_; By whom: \_\_\_\_\_

Action(s) taken: \_\_\_\_\_

**Were Universal Health Care Procedures used while administering first aid or treat? \_\_\_ Yes \_\_\_ No**

Describe procedures used: \_\_\_\_\_

**Additional Assistance Summoned?** Yes \_\_\_ or No \_\_\_. If yes, time of call: \_\_\_\_\_

Ambulance #/Name of Company Responding: \_\_\_\_\_

Police Department/Officer Responding: \_\_\_\_\_

**Was injured transported?** Yes \_\_\_ or No \_\_\_. If yes: By Whom: \_\_\_\_\_

Where: Doctor's Office \_\_\_, Hospital \_\_\_, Camp/Site Health Service \_\_\_, Other \_\_\_\_\_

Person(s) to be notified of transport (attempt to notify immediately and continue efforts):

Name(s) \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to injured: \_\_\_\_\_

Contact Made: Date \_\_\_\_\_; Time \_\_\_\_\_; Method \_\_\_\_\_

**If not transported, subsequent action taken:** \_\_\_\_\_

**Check here if Injured (over 18 or parent or guardian if under 18) refused treatment \_\_\_ or transport \_\_\_.**

*MCE* Persons notified of accident / incident:

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

Describe any contact made with/by the media regarding this situation: \_\_\_\_\_

**Signed:** \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

- |                         |                                   |             |  |
|-------------------------|-----------------------------------|-------------|--|
| Insurance Notification: | 1. Parent's Insurance             | Date: _____ | By: <input type="checkbox"/> Parent <input type="checkbox"/> MCE |
|                         | 2. Camp/Event Health Insurance    | Date: _____ | By: <input type="checkbox"/> Parent <input type="checkbox"/> MCE |
|                         | 3. Worker's Compensation          | Date: _____ | By: <input type="checkbox"/> Parent <input type="checkbox"/> MCE |
|                         | 4. Camp/Event Liability Insurance | Date: _____ | By <input type="checkbox"/> Parent <input type="checkbox"/> MCE  |
|                         | 5. Personal Health Insurance      | Date: _____ | By: <input type="checkbox"/> Parent <input type="checkbox"/> MCE |
|                         | 6. Automobile Insurance           | Date: _____ | By: <input type="checkbox"/> Parent <input type="checkbox"/> MCE |

It is the policy of the University of Maryland, Agricultural Experiment Station and Maryland Cooperative Extension, that no person shall be subjected to discrimination on the grounds of race, color, gender, religion, national origin, sexual orientation, age, marital or parental status or disability. Da2002,dlb